



Occupational Therapy Discharge Report



If applicable, please select the Lock button before submitting the form.
Please note: once the Lock button has been selected, the form will no longer be editable.

INVOICE INFORMATION			
CLAIM NUMBER	DATE OF ACCIDENT (dd/mmm/yyyy)	DATE OF REPORT (dd/mmm/yyyy)	VENDOR NUMBER
INVOICE/REFERENCE NUMBER	PAYEE NAME		
PAYEE ADDRESS			
PAYEE ADDRESS			

CLIENT INFORMATION			
FIRST NAME	LAST NAME	DATE OF BIRTH (dd/mmm/yyyy)	PERSONAL HEALTH NUMBER (PHN)

PRACTITIONER INFORMATION		
FIRST NAME	LAST NAME	PRACTITIONER NUMBER

Assessment

DATE(S) OF ASSESSMENT			
(dd/mmm/yyyy)	(dd/mmm/yyyy)	(dd/mmm/yyyy)	(dd/mmm/yyyy)

DATE(S) OF TREATMENT SINCE LAST REPORT
(dd/mmm/yyyy)

TOTAL NUMBER OF CLIENT VISITS	
OT VISITS	RA/KIN VISITS

Medical And Rehabilitation Information

1. CURRENT MEDICAL STATUS/UPDATE:

Subjective Assessment – Client Interview

2. ONGOING SYMPTOMS/CONCERNS:

Objective Assessment

3. ONGOING SYMPTOM PRESENTATION

Yes No

IF YES, SELECT AT LEAST ONE ONGOING SYMPTOM PRESENTATION:

Pain Headaches Noise/light sensitivity Fatigue/sleep disturbance
 Dizziness Nausea Paresthesia/altered sensation Other : _____

4. UPDATED INFORMATION:

PERFORMANCE COMPONENT

5. PHYSICAL LIMITATIONS

Yes No

If 'No' on Question 5, skip to Question 11

6. SELECT AT LEAST ONE PHYSICAL LIMITATION:

ROM Strength Balance Coordination Other : _____

7. PROVIDE UPDATED INFORMATION ABOUT PHYSICAL LIMITATIONS:

8. LIMITATIONS AFFECTING FUNCTIONAL ABILITY
 Yes No

If 'No' on Question 8, skip to Question 11

9. IF YES, SELECT AT LEAST ONE:
 Lifting/Carrying Pushing/pulling Reaching Hand function Postural tolerances Standing
 Sitting Stooping Sustained neck flexion

10. PROVIDE UPDATED INFORMATION ABOUT LIMITATIONS AFFECTING FUNCTIONAL ABILITY:

11. COGNITIVE LIMITATIONS
 Yes No

If 'No' on Question 11, skip to Question 14

12. SELECT AT LEAST ONE COGNITIVE LIMITATION:
 Attention Initiation Visual scanning/perception Awareness Executive function Other : _____

13. PROVIDE UPDATED INFORMATION ABOUT COGNITIVE LIMITATIONS:

14. LIMITATIONS AFFECTING FUNCTIONAL ABILITY
 Yes No

If 'No' on Question 14, skip to Question 17

15. LIMITATIONS AFFECTING FUNCTIONAL ABILITY

<input type="checkbox"/> Multi-tasking	<input type="checkbox"/> Planning/organization	<input type="checkbox"/> Problem-solving/decision-making
<input type="checkbox"/> Frustration tolerance	<input type="checkbox"/> Communication skills	<input type="checkbox"/> Safety/judgment

16. PROVIDE UPDATED INFORMATION ABOUT LIMITATIONS AFFECTING FUNCTIONAL ABILITY:

17. PSYCHOSOCIAL/BEHAVIOURAL LIMITATIONS

Yes No

If 'No' on Question 17, skip to Question 21

18. SELECT AT LEAST ONE PSYCHOSOCIAL/BEHAVIOURAL LIMITATION

Anxiety Mood Frustration tolerance Social avoidance/isolation Other : _____

19. PROVIDE UPDATED INFORMATION ABOUT PSYCHOSOCIAL/BEHAVIOURAL LIMITATIONS:

20. LIMITATIONS AFFECTING FUNCTIONAL ABILITY

Yes No

IF YES, PROVIDE UPDATED INFORMATION:

FUNCTIONAL STATUS

ADL

21. MOBILITY/TRANSFERS: IS CLIENT ABLE TO PERFORM ON THEIR OWN?
 Yes No

IF NO, SELECT: <input type="checkbox"/> Requires extra time/equipment <input type="checkbox"/> Requires assistance	IF NO, PROVIDE UPDATED INFORMATION:
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22. SELF-CARE: IS CLIENT ABLE TO PERFORM ON THEIR OWN?
 Yes No

IF NO, SELECT: <input type="checkbox"/> Requires extra time/equipment <input type="checkbox"/> Requires assistance	IF NO, PROVIDE UPDATED INFORMATION:
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IADL

23. HOUSEHOLD MANAGEMENT: IS THE CLIENT ABLE TO PERFORM ON THEIR OWN?
 Yes No

IF NO, SELECT: <input type="checkbox"/> Requires extra time/equipment <input type="checkbox"/> Requires assistance	IF NO, PROVIDE COMMENTS:
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TRANSPORTATION

24. PRE-ACCIDENT:

25. CURRENT:

Work Status

26. IS THE CLIENT STILL JOB ATTACHED?
 Yes No

27. IS THE CLIENT EMPLOYED OR ENGAGED IN TRAINING ACTIVITIES? PLEASE INDICATE WHICH ONE(S)
 Full time Part time Self-employed Seasonal Training/Apprenticeship Student Retired Not employed

28. HAS THE CLIENT BEEN ABSENT FROM THE FOLLOWING AS A RESULT OF THE MVA?
Work: Yes No Training: Yes No School/Studies: Yes No

If the client is continuing to work, study or train indicate their status, as applicable

29. STATUS OF DUTIES
Work: Full Modified Training: Full Modified Study: Full Modified

30. STATUS OF HOURS
Work: Full Modified Training: Full Modified Study: Full Modified

31. CRITICAL JOB DEMAND 1 ABLE TO MEET
 Yes No

CRITICAL JOB DEMAND 2	ABLE TO MEET <input type="radio"/> Yes <input type="radio"/> No
CRITICAL JOB DEMAND 3	ABLE TO MEET <input type="radio"/> Yes <input type="radio"/> No
CRITICAL JOB DEMAND 4	ABLE TO MEET <input type="radio"/> Yes <input type="radio"/> No
CRITICAL JOB DEMAND 5	ABLE TO MEET <input type="radio"/> Yes <input type="radio"/> No
CRITICAL JOB DEMAND 6	ABLE TO MEET <input type="radio"/> Yes <input type="radio"/> No
CRITICAL JOB DEMAND 7	ABLE TO MEET <input type="radio"/> Yes <input type="radio"/> No
CRITICAL JOB DEMAND 8	ABLE TO MEET <input type="radio"/> Yes <input type="radio"/> No
CRITICAL JOB DEMAND 9	ABLE TO MEET <input type="radio"/> Yes <input type="radio"/> No
CRITICAL JOB DEMAND 10	ABLE TO MEET <input type="radio"/> Yes <input type="radio"/> No
CRITICAL JOB DEMAND 11	ABLE TO MEET <input type="radio"/> Yes <input type="radio"/> No
CRITICAL JOB DEMAND 12	ABLE TO MEET <input type="radio"/> Yes <input type="radio"/> No
CRITICAL JOB DEMAND 13	ABLE TO MEET <input type="radio"/> Yes <input type="radio"/> No
CRITICAL JOB DEMAND 14	ABLE TO MEET <input type="radio"/> Yes <input type="radio"/> No
CRITICAL JOB DEMAND 15	ABLE TO MEET <input type="radio"/> Yes <input type="radio"/> No
32. IS RETURN TO WORK A GOAL OF REHABILITATION AT THIS TIME? <input type="radio"/> Yes <input type="radio"/> No	
IF NO, PROVIDE COMMENTS:	
33. IS EMPLOYER ABLE TO ACCOMMODATE GRADUAL RETURN TO WORK? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> To be determined	

Summary/Analysis

34. SUMMARY/ANALYSIS:

Recommendations

RETURN TO FUNCTION RECOMMENDATIONS (equipment, services, rehabilitation, other)

RECOMMENDATIONS

RETURN TO WORK RECOMMENDATIONS (equipment, services, rehabilitation, other)

Fill this section if the client is NOT working or working modified duties/hours.

RECOMMENDATIONS

Report Distribution

REPORT DISTRIBUTED TO THE FOLLOWING TEAM MEMBERS

Family physician

Specialist

PT

Lawyer

Other

Service Provider Information

CONTACT PREFERENCE

By phone

CONTACT PHONE NUMBER

By email

CONTACT EMAIL

Additional Comments/Information

By checking this box, I certify that the information provided is true and correct to the best of my knowledge.

Select one of the following:

- I have obtained consent from the client to share all information related to the history, examination, assessment and management of the injury related to the motor vehicle accident with ICBC.
- This report is being provided pursuant to a request by ICBC under Section 28 or Section 28.1 of the *Insurance (Vehicle) Act*.

Personal information on this form is being collected under section 26 of the Freedom of Information and *Protection of Privacy Act (BC)* and section 28 or 28.1 of the *Insurance Vehicle Act (BC)* for the purpose of obtaining a health care report in order to manage the claim. Questions about the collection of this information may be directed to the claim representative, or call 604-661-2800 or contact the Privacy & Freedom of Information department at 151 Esplanade, North Vancouver, BC V7M 3H9.